Aberdeen City HSCP – the importance of having the right support

Key challenge

Changes to national demographics and changes to the Older People's Pathway were key drivers behind Aberdeen City HSCP recognising several years ago that there was a need for a community-based service akin to Hospital at Home.

Context

For older people in the city, the very successful Geriatric Assessment Unit was already in place, but as it was based in the acute sector there was a gap in the community that the Hospital at Home service would be able to fill.

A business case was developed with direction and support from the HSCP leadership team. A steering group was established with clinicians from both primary and secondary care. This steering group supported the Team Leader with implementation of the business case. Having the right people on the steering group (consultant, social work, Leads for Nursing, AHP, senior leadership team representation) facilitated engagement between professions and services leading to good working relationships at the front line. These connections have been invaluable when the team is looking to contact the right people at the right time.

Testing and establishing a business case

The business case described the intention to set up a service that would support one of the, then, four localities in the city. A key element of Hospital at Home was to provide an alternative to hospital admission as well as a pathway that would support earlier discharge from hospital, 'active recovery'. However, due to the inability to recruit to the consultant post within the team, it was decided to test the 'Active recovery' element of the service initially and accept patients who were being discharged from the Geriatric Assessment Unit. Consequently, patients were distributed throughout the entire city, rather than in one locality, effectively immediately expanding from supporting older adults living with frailty in a population of between 80-84,000 in one locality, to including all those in a population of approximately 230,000 across the whole city.

The Aberdeen City Hospital at Home team admitted their first active recovery patient in June 2018 and have been providing an alternative to hospital admission since December of that year. Though the team has expanded and evolved, the GP remained the responsible clinician so any recommendations had to go through the GP. However the service worked closely with an existing service which included a consultant geriatrician who provided clinical supervision, supporting clinical decisions on a part time basis.

In March 2019 the team hit another milestone when they extended the service to seven days a week. This was partly achieved due to recruiting to the team, their existing relationship with the Out of Hours Nursing team and their understanding of how to interface with each other.

Since July 2020 two part time consultant geriatricians, as well as a part-time GP, have joined the service and from March 2021 the service moved to being fully consultant-led.

The importance of measurement and feedback

To measure the difference they are making, the team recorded a number of measures from the first 400 patients treated in the service. These included what they did for them, the reason for admission, where they were in the city and factored in travel time. There is also a lot of qualitative information as they encouraged people to provide their views and have a number of cards sent by people who have used the service. Overall the team received some very positive feedback.

Feedback from the families and carers of the people who use the service has been overwhelmingly positive. Generally they agree that it is a lot less stressful having their family member at home, meaning that they didn't have to make trips to the hospital to see them. They said it was also reassuring to know that there would be support from the team, this helped to reduce any anxiety about someone being treated at home. The team emphasised the importance of having conversations with families and carers to highlight the benefits of being treated at home.

A formal evaluation programme was also commissioned by the leadership team and carried out over the first 6 months during which time the service was very much in its infancy. Despite this, the evaluation found very positive themes around support for unpaid carers and real benefits to patients.

Support from others

Getting internal support is important to progress elements of the service, for example pharmacy and prescribing pathways. Overcoming the challenges associated with Consultants prescribing in a community role with the consultants now having hospital based prescription pads and the non-medical prescribers having prescription pads for the Hospital at Home 'virtual' practice code has been a big win for the team.

In additional to the clinical and wider service support, the team connected with people for the practical resources that they needed, working with the planning and IT teams. For physical space, the two amalgamated teams shared one room, although when everyone was present the room wasn't big enough to fit them all. Following identification in the business case, funding for resources was allocated to the team, giving them some much needed equipment. They also gained a base, which fitted all of them and made a huge difference to team dynamics.

Being able to learn from the wider community of Hospital at Home services is important also. The Aberdeen City team have found the Healthcare Improvement Scotland run Hospital at Home webinars really helpful, especially since the COVID-19 pandemic as they helped to provide information on what other areas were doing and therefore what the team in Aberdeen could potentially provide. The role of Healthcare Improvement Scotland has also helped Aberdeen City, Aberdeenshire and Moray work together through Grampian-wide workshops. The sharing of information between teams allows others to avoid going down the same rabbit holes.

Learning points

Some key learning points from the experience of Aberdeen City HSCP are:

- Seek opportunities, however small they may seem
- Try something different and new, there is always something to learn from barriers and challenges
- Try set aside time for a training schedule – this would allow staff to develop and improve their skills without putting additional pressure on the capacity of the team.

Next steps

There are some next steps that the team are considering. One of these is electronic notes so that information can be shared more effectively to help support patients. The team are delighted to have a consultant as the responsible clinician as this supports immediate prescription changes rather than relying on the GP to do this. The consultant role also allows the team to admit more acutely unwell patients.

Following the receipt of additional funding from Scottish Government, the team is going to test a pharmacist role in the service which will be key in developing the service. The team will look to see what a difference the pharmacist role makes to the service to decide on whether to aim to make it a permanent position.